TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, November 14, 1894.

The President, ROBERT ABBE, M.D., in the Chair.

HIP-JOINT AMPUTATION FOR SARCOMA OF FEMUR.

DR. CHARLES K. BRIDDON presented a man, twenty-three years of age, upon whom he had done a hip-joint amputation. This man was admitted to the Presbyterian Hospital, June 11, 1894, on account of a fusiform swelling of the lower half of the thigh, which diagnosed to be a sarcoma of the femur. He was slightly emaciated, but otherwise in fair general condition, without evidences of similar trouble elsewhere in the body. June 18 he was subjected to operation. Hæmorrhage was controlled by Wyeth's pins and stout rubber tubing. A raquette incision on the outer side of the thigh was made.

Skin flaps dissected up and retracted; the structures over the great trochanter were divided down to the bone, the attachments of the psoas and iliacus muscles severed, the capsule of the joint cut circularly near the margin of the acetabulum, and the head of the femur wrenched forcibly from its socket, the ligamentum teres being torn away in so doing. The head of the bone being out of the acetabulum, the various muscular layers were divided circularly, and the amputation completed. After the removal of the extremity the blood-vessels in the flap were secured and ligated, and the tubing and pins removed. Perfect hæmostasis being obtained, a small drain of iodoform gauze was introduced into either end of the wound leading down to the acetabular cavity, the flaps approximated with silkworm-gut sutures, and a snug aseptic dressing applied. An examination of the amputated limb showed the presence of a fusiform sarcoma of the femur, pronounced later by the pathologist to be of the small wound-celled variety, extending below almost to the knee-joint, and above to such

a limit that, had the femur been sawn through in the operation instead of disarticulated at the hip-joint, doubtless many of the sarcoma cells would have been set free in this way in the wound.

So little blood was lost during the operation that the patient suffered scarcely at all from shock. Healing progressed rapidly. From the time of the operation the patient's general condition began to improve, and on August 24 he was discharged, the wound being healed.

EXTRA-UTERINE PREGNANCY; LAPAROTOMY.

Dr. Charles K. Briddon presented two patients upon whom he had made abdominal section for the relief of extra-uterine pregnancy. In the first case, that of H. H., aged twenty-eight years, the history was as follows: Six years before she had borne a child; ten weeks before she began to have remittent pelvic and lumbar pain, which was followed in two days by flowing. Pain and hæmorrhage continued for two weeks, and then the patient passed some material which was called, by the family physician, an abortion at two months. The pain, however, continued; the abdomen increased in size, and there was considerable loss of general health. When admitted her abdomen was large, and there was marked resistance and tenderness, especially over the right side. By vagina a mass could be felt filling up the cul-de-sac of Douglas, the uterus being pushed well forward. It was tense and tender, and apparently contained fluid. On July 11, Dr. Briddon made a median abdominal incision four inches long, which exposed the uterus, large, soft, and adherent to the small intestines. After tearing away the adhesions a large mass was seen behind the uterus extending laterally in both directions. This was opened, and a number of old clots besides fresh blood escaped. The placenta was situated to the right and high up. Rapid separation of placental tissue, and free use of hot water controlled the hæmorrhage, which was very free. The fœtus was contained in a cyst on the left side of the pelvis, whilst the unusually-developed placenta was intimately adherent to the viscera on the right side, when an attempt was made to peel this off; the hæmorrhage was of a very serious character; it fairly welled up. The only way to deal with it was to separate the adherent mass as rapidly as possible, inundate with hot water, and trust to the introduction of a voluminous tampon, and this succeeded, though the patient was in a very precarious condition.

The condition of the patient after operation was exceedingly bad, and an intravenous infusion of twenty-four ounces of salt solution with free use of stimulants was required.

The fœtus was of about three to four months' development, not macerated. Evidently died just before or during the operation. Recovery was uneventful. Wound healed slowly by granulation, and patient was discharged cured September 11, 1894.

The second patient, M. G., twenty-seven years of age, entered the service of Dr. Briddon in the Presbyterian Hospital, on January 1, 1894, with the following history: She had menstruated normally since the age of sixteen. Three years ago she was married. Since then she has had two children; the first born two years ago, the last one year ago. She nursed the last child, and noticed no flow till seven weeks ago, when she had some bloody discharge. It lasted, however, for only two days, and did not return till two weeks ago. Since then she has had some bleeding on and off. Ever since the return of the flow, seven weeks ago, she has had more or less pain, referred at first to the abdomen generally, later localizing itself in the pelvis. A week ago she passed some shreds of tissue from the vagina, intermingled with clotted blood.

On admission she complained of varying pain in the lower part of the abdomen, especially on the right side, not very severe. Examination by the vagina detected a mass, the size of an orange, behind and a little more to the right of the uterus, somewhat tender. By external palpation of the abdomen, a certain sense of resistance could be felt low down on the right side.

January 3, Dr. Briddon made an incision midway between the umbilicus and pubes, through which a mass was revealed posterior to and somewhat to the right of the uterus; size about that of a small orange. It was fixed by firm adhesions to the uterus, somewhat less so to the small intestines. Adherent to it above also was the appendix. This was ligated and removed. Attention was now turned to the mass itself, which was seen to have its place between the layers of the broad ligament. Its surface was of a dark bluish color, and deeply congested. In separating it from adhering parts a "blood cyst" was opened into. The blood was removed on sponges, and the mass finally freed from its adhesions to surrounding parts, tied off with silk and cut away. The mass thus removed was made up of the right ovary and tube, the broad ligament, "blood cyst," and adhesions. The cyst was seen to contain, in addition to some clotted

blood, a small mass, the size of an English walnut, containing indistinct fœtal remains. The left ovary and tube were normal in appearance; they were therefore not disturbed. The bleeding from the torn adhesions was controlled by a strip of iodoform gauze, passed to the bottom of the wound, and left in for drainage. The upper two-thirds of the incision were closed with silkworm-gut sutures, an aseptic dressing applied, and the patient returned to the ward. She made a good recovery. The wound healed rapidly, and on February 10 she left the hospital a well woman.

She now returns in the ninth month of normal pregnancy.

PYONEPHROSIS; NEPHRECTOMY.

Dr. Briddon presented a woman, fifty-two years of age, in whom removal of the left kidney had been done by him for the relief of abscesses therein. In September, 1892, she had been first seized with severe pain in the left lumbar region, which lasted for two hours, and was followed by fever and sweating. Eight similar attacks have since occurred. During these attacks the urine remains unchanged in character or quantity. During past six months the septic symptoms have been constant, with much deterioration of general health.

On admission the urine contained 15 per cent. of pus, but was otherwise negative. A tumor was also discovered, five inches by three inches, in the left side just below the free margin of the ribs, which was movable and somewhat tender. September 26, she was subjected to operation. Her general condition was so extremely bad that free use of stimulants had to be resorted to. An incision was made six inches along the outer border of the left erector spinæ. The kidney was found very much enlarged, and the connective tissue immediately outside the capsule was traversed everywhere by enlarged tortuous vessels, so that, if an attempt had been made to enucleate within this investment, it is probable that the patient's life would have been compromised by hæmorrhage. To make room, the vertical incision was supplemented by a transverse one, five inches long, commencing midway between the extremities of the first. In separating the adhesions near the hilum a cavity was opened, which contained about eight ounces of thin purulent urine. This was evacuated and the kidney brought into the wound. The pedicle was isolated and transfixed by an aneurism-needle holding strong silk.

The patient's condition was so bad as to preclude any satisfactory examination of the ureter. The wound was partially closed with silkworm-gut sutures, and a tamponnade of iodoform gauze was introduced to the bottom.

About pulseless when removed from the table, a saline infusion was given besides free stimulation. Her condition was precarious until morning, when reaction was fairly established.

Examination of the kidney after removal showed the pelvis and calyces to be much dilated. There were areas of simple inflammation distributed throughout the kidney tissue, with dense infiltration with leucocytes, especially near the mucous membrane of the pelvis; also small foci near the capsule. The tubules in some places were normal and in others obscured by leucocytes. The after-history of the case was uneventful. September 27, she passed thirty-two ounces of urine; October 1, thirty-five ounces; and November 2, sixty-five ounces. Pus has almost disappeared, there only being a trace at the present time.

All ligatures came away by November 2. Wound now is a small, healthy, granulating sinus. General health is very much improved.

EXOPHTHALMIC GOITRE.

Dr. Briddon presented a boy, seventeen years of age, who was the subject of exophthalmic goitre. He called attention to the prominence of the eyes, and said that over eight weeks ago, when he first saw the patient, the thyroid tumor was much larger than at present. The only treatment used had been iodide of potassium in increasing doses, the amount taken at present being twenty grains three times a day. The effect on the goitre had been marked, but the eyes were as prominent as before.

He inquired whether any of the members had tried the method which some German surgeon had advocated of simple division of the thyroid isthmus. He was unable to understand how it could act, but would be disposed to try it in preference to thyroidectomy. Iodide of potassium had been tried in other cases without avail, and possibly the diminution in the size of the goitre following its use in this case was merely a coincidence.

Dr. Kammerer said he had operated in two cases of exophthalmic goitre some years ago, and they were the only ones which he had lost out of a considerable number of extirpations for cystic, parenchymatous, and malignant tumors of the thyroid. In one of these instances he tied

the four thyroid arteries according to Rydygier. In the other, excision was made of the greater part of both lobes, which were much enlarged. The operation was at first well borne, the patients coming out of the anæsthetic nicely, but the pulse soon began to increase, running up to 220–240 before death. Cyanosis set in, and both patients succumbed to these symptoms about twenty hours after operation. Careful dissection, made after death, failed to reveal any injury whatever to the sympathetic or pneumogastric nerves. The speaker believed, however, that lately some surgeons had little fear of extirpation in these cases, and that even in this city very good results had been thus achieved. But other operators had warned against extirpating these tumors, and had recommended ligation of the arteries instead. Dr. Kammerer's own experience had made him wary about operations for this condition, especially when the tumors were large, as in the two cases mentioned.

In reply to an interrogatory by Dr. Briddon, Dr. Kammerer said the pulse before the operation in his cases had been variable, running as high as 120.

Dr. Willy Meyer remarked that while simple division of the isthmus of the thyroid might have been done, it certainly had not been generally accepted as of any value. According to recent literature it would seem that the correct treatment was partial or total extirpation. Hahn, of Berlin, had found removal of the tumor on one side followed by cessation of the exophthalmus on that side, and a later operation on the other half had been followed by the same result. All the nervous symptoms disappeared. This would seem to confirm the theory that the origin of the disease was local, situated in the goitre itself, and not in the sympathetic nerve. The only correct treatment, therefore, would seem to be extirpation, internal remedies having proved useless.

ILEO-COLOSTOMY FOR FÆCAL FISTULA BY MURPHY'S OBLONG BUTTON.

Dr. Willy Meyer presented a young man of twenty-two years, with the following history: On the 22d of September, 1891, during sleep, part of a falling ceiling struck him on the abdomen. He experienced intense pain and was unable to work next day. Several weeks later a swelling developed which compelled him to give up work. A physician made a small opening into the abdominal swelling and gave exit to a large amount of pus and some fæcal matter.

A fæcal fistula was thus formed which afterwards would alternately close and open. For some weeks, prior to Christmas, 1893, he was able to work again, but at this date the fæcal fistula reopened, he entered the German Hospital the latter part of May, 1894. At this time nothing was visible but a small sinus which admitted a probe upward and downward, evidently into the peritoneal cavity. An incision was made parallel to Poupart's ligament which was met by a shorter one perpendicular to it on the outer side of the rectus, in order to give access to the neighborhood of the vermiform appendix, as it was thought this organ might be the cause of the trouble. It was found perforated near its base, in the midst of a matted coil of intestine and was removed. Dr. Meyer had been very careful in separating the adhesions, yet on the third day following the operation a larger amount of fæces passed through the wound. This baffled treatment, and it was decided to make a free incision in the median line, search for the loop of intestine which was the origin of the fistula, and make anastomosis between the parts above and below the fæcal fistula, which was done August 16. He regretted not having, before opening the abdomen, introduced a probe into the fistula, to be left in place during the operation, since it proved impossible without such a guide to positively locate the affected loop of intestine from within. Lateral anastomosis being made, between the loops of the ileum, which seemed to lead to the fistula and the transverse colon. The longer button of Murphy was employed. Its introduction was as easy as that of the round button; the incision into the gut needed only a trifle longer to strengthen the union, three Lembert silk sutures were put in at the one pole, where the two parts of the button seemed to separate a little. Then the parts were dropped back and the abdominal wound closed, the patient made a good recovery. He passed the button on the tenth day without any difficulty. The button measures two and a half by five-eighths inches. The fæcal fistula did not close so far. The benefit derived from the operation till date is that the patient has a normal movement of the bowels every day. Formerly he was continuously constipated, drugs were needed to produce defecation. He has gained fifteen pounds since the operation.

THREE CASES OF GASTRO-ENTEROSTOMY BY MURPHY'S BUTTON, FOLLOWED BY RETENTION OF BUTTON IN THE STOMACH.

Dr. Willy Meyer had intended to present a patient upon whom he had performed gastro-enterostomy by Murphy's button on August 23 this year. But he had died from acute cheesy pneumonia three days ago. He now was able to show the very interesting specimen. The man was thirty-nine years of age, had had stomach trouble for nearly a year, had come under the care of Dr. Max Einhorn, of this city, who made careful examination of the stomach contents a number of times, and made the diagnosis of cancer of the pylorus, based on so-called ischiochymia, a term introduced by Dr. Einhorn, and absence of hydrochloric acid. No tumor, however, could be felt. Dr. Meyer was requested to operate. The liver overlapped the stomach, but was not adherent to it. The pylorus was found constricted by a new growth, as had been predicted by Dr. Einhorn. It had been Dr. Meyer's intention to resect the tumor. But there were a number of infiltrated glands in the greater omentum; and on following down the gut he came to another growth at a distance of twenty-six inches from the pylorus. Consequently he abandoned the idea of making resection, and instead united the gut with the stomach anteriorly, according to Woelfson, by means of Murphy's button. The patient was making an ideal recovery until the seventh day, when he was suddenly taken with excruciating pain in the abdomen and vomiting. Thin passages followed administration of small doses of calomel, proving that there was not obstruction of the colon by pressure, and it was concluded that the sudden illness was due to the button falling into the stomach instead of passing on into the intestine. The vomiting, pain, and feeling of weight in the stomach gradually ceased, however. The patient remained in the hospital for a time, gained in weight sixteen pounds within two weeks. Then he began to cough and to expectorate. Tubercle bacilli were found in the sputum. Formerly the man had always been healthy, there was no family history of tuberculosis. It evidently was a hospital infection. Acute cheesy pneumonia developed, which led to death three days ago. Patient was able to eat and drink until his death. He did not vomit, had no pain in the stomach. Post-mortem showed the button in the stomach, as had been diagnosed.

Dr. Meyer had performed gastro-enterostomy with Murphy's but-

ton in another case of cancer of the pylorus, and this patient also was taken with some pain and vomiting on the sixth day, the symptoms continuing two or three days. Five weeks after leaving the hospital the man died of thrombus of the femoral vein becoming detached and probably entering the lung. It was probable the button in this case also had fallen into the stomach and given rise to the symptoms named, for it had not passed per rectum during the three weeks the patient remained in the hospital. Dr. Meyer said it was only natural that the button should fall into the stomach on becoming loose about the seventh day, the gut having been attached to the anterior wall of the stomach and the patient still lying on his back. For this reason he would hereafter follow Von Hacker's method, and attach the gut to the posterior wall of the stomach. In his first case of pylorectomy he attached the outer end of the duodenum to the posterior wall of the stomach, and the button, of twenty-eight millimetres diameter, was discharged per rectum with ease on the twenty-first day after the operation.

The specimen showed the opening exactly the size of the button, its edges were soft. It was Dr. Meyer's opinion there would have been no contraction even had the patient lived many months instead of only three.

Dr. W. W. Van Arsdale related the case of a man, forty-six years of age, upon whom he had operated in July, 1894, for the relief of carcinoma of the stomach. On opening the abdominal cavity a large tumor of the pylorus was found, spreading in the walls of the stomach and duodenum; with the involvement of numerous lymphatic glands.

The stomach was incised sufficiently to admit a finger for exploration of the posterior wall. The small intestine was then pulled up through the meso-colon transversum into the cavity of the lesser omentum, and attached to the posterior wall of the stomach by a small-sized Murphy's button. The condition of the patient not warranting delay, the abdomen was closed by silkworm-gut sutures.

Patient died ten days later from inanition; had no pain; vomited once on ninth day. Had had rectal feeding for three days.

Autopsy revealed a large anastomosis; no peritonitis. The button was found in the stomach. Cause of death. Perhaps due to knuckle of intestine becoming constricted in the opening in the meso-colon.

CARCINOMA OF COLON; LATERAL BUTTON ANASTOMOSIS; RECOVERY; LATER RESECTION WITH END-TO-END BUTTON; ANASTOMOSIS; DEATH.

Dr. R. Abbe related the following case: A woman was admitted to hospital with history of ten days' complete obstruction of the bowels with vomiting only of bile and food. Her previous history was negative, her bowels having always been free.

April 25, 1894, a median laparotomy was done. The small intestines and colon were found distended with fluid fæces and gas and greatly congested down to the lower end of the descending colon. The sigmoid flexure was empty. A small, solid, cylindrical carcinoma limited the distended gut just above the sigmoid. The patient was not in condition to endure a resection, owing to the ten days' obstruction, for which reason a lateral anastomosis above and below the cancer by Murphy's button was accomplished.

The time taken for the anastomosis work was not less than twenty-five minutes, owing to the necessity of evacuating considerable fæces and cleansing the soiled gut.

The abdominal wound was closed tightly. Several good movements ensued the following day. Considerable delirium ensued, with tenderness over the site of the anastomosis, for which ice-coil was used. Convalescence progressed after the end of a week, but the button never passed from her.

Six weeks later, the patient having been about and out driving, an operation was undertaken to resect the cancer, as considerable pain was experienced in the side. A six-inch incision was made to the left of the rectus.

The anastomosed gut was found fixed by adhesions. Section of the gut below and above this point was made, and the end-to-end anastomosis made by a large button, which fitted rather snugly in the lower end. This new anastomosis was dropped back into the belly, and the diseased portion excised.

The cancer was not free, as when felt six weeks before, but had grown to and invaded the *lumbar* wall.

A lumbar counter-opening was therefore made, and the anterior wound closed.

The patient was not in very good condition after operation, and on the next day a saline venous infusion was given.

She vomited a little and had pain for some days.

On the fourth day fæces appeared at the lumbar wound.

On the sixth day a free opening of the wound anteriorly revealed sloughing of the intestine on either side of the button, and extravasation of fæces in the region though not into the peritoneum.

On the seventh day she died, exhausted, though free fæcal evacuation occurred at the wound.

RESECTION OF CAPUT COLI AND ASCENDING COLON FOR CANCER; ILEO-COLIC ANASTOMOSIS BY MURPHY'S BUTTON; DEATH.

Dr. Abbe also related the history of a man, J. H. C., forty-two years of age, who, after having had for one year symptoms of iliac fossa pain, presented a hard nodular mass in the caput coli region with pain but no obstruction. Symptoms of appendicitis led to operation by Dr. Murray, June 7, 1894, but this resulted in finding a shrunken appendix tied down by lymph, which was removed.

A cancer mass just above the caput coli was discovered, and the patient allowed to recover until resection was deemed best.

Pain, fever, and cachexia continuing, he was operated on by Dr. Abbe, July 11 following. The growth, with five inches of the colon, including the complete caput coli and three inches of the ileum, were resected with almost no hæmorrhage.

An end-to-end anastomosis of the ileum and colon was made easily with a medium-sized, easy-fitting, Murphy button.

At the end of the second day he had grown restless; temperature 100° F.; had pain in abdomen, tympanites, and vomiting. He had a strong and repeated desire to defecate, but was unable to, even with the aid of a high enema. Hiccough set in on the third day. Saline cathartics had been given without effect. On the third day, nausea and hiccough continuing, the wound was opened, and the greatly-distended ileum incised after suturing to the abdominal wall. A large amount of fluid fæces escaped and gave great relief. By evening hiccough and nausea ceased.

On the following day vomiting and delirium set in, and on the sixth day he died. The temperature had remained low, but rose to 101° F. before death.

Autopsy showed no peritonitis, but an empty colon below the button and a hard plugging of fæces in the button, which formed complete obstruction.

CHOLECYSTENTEROSTOMY BY MURPHY'S BUTTON.

Dr. Abbe said also that in October, 1893, he did a cholecystotomy for profound cholæmia and exhaustion, which had progressed painlessly for four months, the patient being a woman, forty years of age.

He found a small hard tumor of the common duct. Subsequently she discharged daily one pint of bile through the fistula, and gained health.

On February 20, 1894, he reopened the abdomen, and found general adhesions about the gall-bladder. There was but little increase in size of the tumor. He thrust needles into it to search for stone, but these entered it as if it were a hard cancer throughout. He then united the duodenum and gall-bladder with little trouble by a Murphy button. Perfect recovery ensued.

Five months later she had one day a bilious colic, and quite recently (October 20) had had a similar attack.

END-TO-END ANASTOMOSIS OF THE ILEUM BY MURPHY'S BUTTON.

Dr. Willy Meyer presented the specimen from the case which he had related in May, and operated upon March 3, for tumor of abdominal wall extending to and obstructing the gut. Tumor and adherent gut were cut out in one piece at that time, and anastomosis was made by Murphy's button. The patient died ten weeks later of acute intestinal hæmorrhage. Post-mortem showed metastatic growths all over the intestine and manifold adhesions. The point of anastomosis could be detected only by the presence of a few silk stitches which had been inserted during the operation. There was not the slightest contraction. The linear cicatrix was about three millimetres wide. The anatomical result is ideal.

Dr. Meyer also remarked upon possible danger of gangrene from use of a button of too large size, and of obstruction if one too small were used on the large intestine. It had been his custom to commence feeding by the mouth within twenty-four hours after the operation, and he had had no cause to regret it. He would propose, in using the button on the large intestine, to begin with repeated small doses of a cathartic on the third or fourth day. It seemed that obstruction of the central canal of the button by hardened fæcal matter might thus be avoided. He had used the button in eight

patients, all of whom recovered as far as the operation with the button is concerned. Among these eight operations one had been done on the ascending colon and one on the rectum. He had not experienced obstruction. In both cases the button was passed on the eleventh day. He was unable to understand why the button should have fallen back into the stomach in Dr. Van Arsdale's case where posterior anastomosis had been made according to the method of Von Hacker. He thought that after a number of cases treated in this manner should come to be recorded, this one, in which the button had failed to pass downward, would be found to be an exception.

Dr. Abbe thought the falling back of the button into the stomach was a matter of some importance. One patient he had operated upon did not pass the button, and it was found six weeks later to have fallen back into the loop of bowel on the proximal side of the union. In end-to-end anastomosis between portions of the gut and in cholecystenterostomy it was uniformly swept on. Might it not give rise to trouble as a foreign body should it remain long in the stomach? The method of anastomosis was certainly an easy one, and destined to have a wide field of application, although further experience might narrow its boundaries in some directions. The button-method possessed two important advantages, one being that a disk of the intestine was punched out; the other that the line of pressure gave a narrow cicatrix and comparative freedom from contraction. In the case of cholecystenterostomy, which he had related, it was probable some contraction had already taken place. It was a mistake to make the buttons too large. He thought a button one inch in diameter for the colon was plenty large, even for end-to-end anastomosis, if one could be assured against contraction. The use of too small a button in the colon was also a mistake, as had been shown in one of the cases related. It was evident a fatal issue would not have resulted had the fæces been able to pass through the lumen of the button.

Dr. Kammerer mentioned a case which demonstrated that the button might go the wrong way, not only in operations upon the stomach, but also upon the intestine. It was in a case of fæcal fistula at St. Francis's Hospital, the fistula having resulted from gangrenous hernia, anastomosis made with the button about one foot above the fistula by Dr. Murphy himself. When Dr. Kammerer, who was in Europe at the time, took the service about thirteen weeks later the button had not been passed, but could be readily reached from the fæcal fistula which still persisted. He enlarged the fistula, taking

pains not to open the peritoneum, and after much trouble succeeded in extracting the button. The patient did well for six days, then suddenly the temperature rose, and she developed symptoms of subacute peritonitis and died. The post-mortem examination, which the speaker was unable to attend, showed general peritonitis. The anastomosis separated, while the bowel was being removed, without any force having been employed, and the sharp edges of the incisions into the bowel showed that the adhesions, even after thirteen weeks, must have been very slight,—perhaps an advantage of the method. The speaker did not believe that the peritonitis was due to a separation at this point, but another cause for it was not apparent.

The tendency of the button to fall back into the stomach had led Dr. Kammerer to prefer suture in gastro-intestinal anastomosis; in certain cases of intestinal anastomosis, and especially in cholecystenterostomy, he thought the button, which was a very ingenious mechanical device, could be employed with great facility.

LARGE SARCOMA OF KIDNEY IN A CHILD; NEPHRECTOMY; RECOVERY.

Dr. W. B. Coley presented a child and photographs, illustrating the appearance before and after nephrectomy for large sarcomatous kidney. The patient, a little girl aged five years, was operated upon September 25. An incision four inches long was made parallel with the rectus abdominis, and was met by a shorter transverse incision at right angles to the vertical; the tumor was adherent to the overlying colon and other structures, but could be shelled out. Only two or three ounces of blood were lost, and there was but slight shock. The pedicle was not larger than one's little finger, was ligated with silk, gauze drain was introduced outside of the peritoneum, and along its track there still existed a small sinus. The patient had gained in flesh and strength, and in view of the success attained in two similar cases by Dr. Abbe there was reason to hope the cure would prove permanent. The tumor proved to be a spindle-celled sarcoma, and weighed three pounds.

EXTRAPERITONEAL URETERO-LITHOTOMY.

Dr. Charles K. Briddon then read the paper of the evening, entitled case of "Extraperitoneal Uretero-Lithotomy, following Nephro-Lithotomy and Nephrectomy." (See page 29.)

Dr. Charles McBurney had had a case not long since in which the calculus rested in the lower part of the ureter, the diagnosis having been made without much difficulty per rectum. Suprapubic cystotomy was performed, the bladder was opened widely, a curved probe-pointed dilator was used to stretch the lower end of the ureter large enough to admit the tip of the little finger, the calculus was reached, was broken up into fragments, and when removed weighed altogether 130 grains. The operation was slow, but no injury was done any of the tissues. The ureteral orifice would have permitted even wider dilatation than was made. The patient had been well since.

Dr. Briddon remarked that Dr. Emmet had in several cases removed calculi from the ureter through the vault of the vagina. Several cases had also been reported in which the stone had been taken out by suprapubic incision, but only where it lay close to the orifice of the ureter. In his own case the stone was situated higher. The suprapubic operation was not without danger even where the stone was within reach through the orifice, unless in the hands of the very expert, for one case was on record in which the peritoneum had been opened, resulting in fatal infection, and in his judgment the preferable method in such cases would be to attack it from behind by the modification of Kraske's sacral resection modified by Cabot, of Boston.